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Headline: New bandage stops bleeding
By Douglas J. Gillert, American Forces Press Service

SAN ANTONIO, Texas -- If the fibrin bandage had been around during the Vietnam War, said Army Dr. (Lt. Col.) John Holcomb, there'd be 6,000 fewer names on the memorial wall in Washington.

Laboratory tests of the bandage have convinced Holcomb and others that the revolutionary dressing could prevent at least 20 percent of battlefield deaths attributed to bleeding.

Holcomb joined the Army-American Red Cross team developing the bandage in 1995. He'd just returned from combat duty in Somalia.

"I had guys who died because I couldn't stop their bleeding," Holcomb said. "Forty-nine percent of the soldiers who die on the battlefield die of hemorrhaging. Twenty percent of those deaths would possibly be preventable by newer methods of control. But we still use gauze sponges that the Roman Legion used thousands of years ago."

Distressed by his Somalia experience, Holcomb volunteered to help develop a better bandage. Today, he's readying the fibrin bandage for final testing and Food and Drug Administration licensing. As chief of military trauma

research at the Institute of Surgical Research, Fort Sam Houston, he's leading laboratory tests of the bandage that he said stops bleeding in seconds.

This isn't your typical bandage. First off, it's stiff and brittle, like polystyrene. Second, each 4-inch-square dressing currently costs $1,000. The price likely will drop dramatically once mass production begins, Holcomb said.

The quarter-inch thick bandage contains fibrinogen and thrombin, the body's natural clotting proteins. The mixture is dried out and densely coated on an absorbent backing. Applied to a large open wound, the bandage softens and attaches itself to the wound, interacting with the body's blood and causing rapid coagulation.

"It's a very natural way of stopping bleeding," Holcomb said. "The same material could be used in its nonhardened state, as foam administered through an IV."

Holcomb said he foresees both field and surgical uses for the bandage. "Medics can carry fibrin glue bandages with them into battle and apply them to wounds," he said. In operating rooms, it could be used to stop severe bleeding, such as on the liver." You can leave the bandage inside, he said, because the body breaks it down and absorbs it over time.

The biggest customers probably will be emergency medical technicians and emergency rooms, Holcomb said. But first, the product must undergo human testing during clinical trials, which are prohibited in military hospitals because of patient consent requirements.

"Every trauma center in the country is interested in the bandage," Holcomb said. "We'll pick places that are busy, that get 500 to 600 patients a year." The FDA must approve the trials. Holcomb said he sees that happening within the next two years, with commercial development and licensing coming a few years later. He's enthusiastic, however, and believes the bandage will someday save lives.

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Headline: Friendly skies promote vision care

By Tanya C. Brown, Bureau of Medicine and Surgery

WASHINGTON -- Commander Warren Anderson, Medical Corps, has taken a new approach to eye care. And his initial take off has sent awareness of eye disease to new heights.

With an aerobatics airplane painted red white and blue and “Flight for Sight” written across its wings, Anderson is racking up frequent flyer miles at local air shows to provide preventive eye problem screening and giving literature to those assembled to see his show.

“It’s a way to combine my interest in flying with a passion for what I do for a living,” said Anderson, an ophthalmologist and Senior Flight Surgeon at Naval Air Facility, Washington, D.C.

Flight for Sight is a program organized by Anderson to provide public awareness and education regarding diseases of the eye, eye safety and proper vision care.

Anderson, along with regional chapters of Prevent Blindness America and the American Academy of Ophthalmology, set up booths at local air shows that give people the opportunity to be screened for glaucoma, cataracts and other eye diseases. In addition, they answer questions about vision risks and promote eye safety at work and home through pamphlets and other literature.

"The whole idea is to have an activity that is unique," said Anderson, who began the program in 1998. "The performance gives me the opportunity to reach people, because they are in a more relaxed atmosphere and it's easier to reach people when they are relaxed."

It's the performance that draws the crowd, Anderson said. People see his plane performing aerobatic stunts and it piques their interest. Passers by see the airplane parked next to the Flight for Sight booth and are encouraged by volunteers to pick up literature and receive a free eye screening.

During Anderson's first show at Reading Aerofest 98, in Pennsylvania, about 1,000 people received exams and acquired literature. Anderson said that by next year he hopes to attend more shows and reach nearly 2 million people.

"When you can entertain and educate people at the same time, it's well worth it," said Anderson.

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Headline: Nurses' training pays off for victims of traffic accident

By ENS T.J. Leach, Medical Service Corps, Naval Medical Clinic Pearl Harbor

PEARL HARBOR, Hawaii -- While driving along the freeway last summer, LCDR Bruce Godwin, Nurse Corps, and his wife Barbara were good citizens when they assisted victims of an automobile accident.

"We were driving on the overpass by Pearl Harbor and noticed the accident on the [expressway]," said Barbara Godwin. "There seemed to be nobody helping out, so we went up to the next exit and turned the car around and stopped to help."

There were two victims, one trapped in the car and another who was ejected from it.

Their training as nurses became instant assets for the Godwin family. Barbara, who is a nurse practitioner, provided aid to the person inside the vehicle, while her husband assisted the ejected victim. They used their nursing skills to treat both victims until the Honolulu Fire Department and paramedic units arrived.

The accident was so severe the fire department used "jaws of life" tools to open the vehicle and remove the injured person. The Godwins continued providing assistance until the patients were loaded into the ambulance.

At a ceremony in December, the fire department honored the Godwins, along with other people who assisted the fire department throughout the year in medical, fire and water

rescues. Fire Chief Attilio Leonardi called all of the honorees bonafide heroes.

“The Honolulu Fire Department came out today to give a small token of appreciation for all of those who decided not to turn the other cheek, but to get involved and help out another who was in trouble,” he said.

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Headline: Navy medical team aids Guatemalan boy

By Pfc. Tina M. Beller, Joint Task Force Aguila, Guatemala

SAN JOSE, Guatemala – American assistance to the people of Central America is not only roads and bridge repair and providing food and medicine. Occasionally, American help can be emergency first aid.

A Guatemalan boy, in late December, sliced his forearm as he tried to cut open a coconut with a machete. The fourteen-year old boy, known only as Ismael, was found by Hospital Corpsman Third Class Jeremy Cadovius, who immediately applied a pressure dressing to the boy’s arm. Cadovius phoned ahead to the base medics, while he rushed the boy to Joint Task Force-Aguila headquarters.

“The boy had a laceration of about four centimeters with a cut through a small artery and vein,” said CDR Raymond S. Turk, Medical Corps, the head anesthetist for the Navy medical group.

Ismael’s wound was immediately cleaned with a saline wash followed by exploratory surgery and the administration of a topical anesthetic by LCDR Kathleen M. Casey, Medical Corps.

“Once the wound is clear, we can explore for torn tendons, good arterial pulse, and nerve damage,” said Casey. “He was capable of moving his hands and feeling his fingers, so we knew he hadn’t suffered severe damage.”

Working with Casey, Hospital Corpsman Second Class Suzanne M. Allen, the surgeon’s assistant, closed the young boy’s wound with 12 stitches.

However painful the experience may have been for Ismael, he left the field hospital with a cleaned and stitched wound, a plastic bag bursting with chocolates and a thankful smile on his face.

Lieutenant Max C. Cormier, Nurse Corps, said Cadovius did the right thing. “He was sent to provide medic support, and he did just that,” said Cormier. “He immediately applied a pressure dressing and phoned for help. He did an outstanding job.”

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Headline: Search and rescue teams save victims of boat sinking

By LT Eileen M. Knoble, Nurse Corps, Naval Hospital Roosevelt Roads

ROOSEVELT ROADS, Puerto Rico -- Responding to individual calls for help is nothing new to Search and Rescue (SAR) teams. Recently, the Naval Hospital Roosevelt Roads SAR team received a call for help from a boat that was

burning and sinking with more than 40 people on board. Two crews promptly responded and at 10:30 p.m. they were racing to the scene, 90 miles into the Caribbean sea. According to SAR team member, Chief Hospital Corpsman (AW/NAC) David C. Constantine, there was very little moonlight to help the night search, but at least the seas were not too rough. According to Constantine they searched until 3 a.m. and were unable to find any survivors.

The following morning, the SAR crew was on scene at first light looking for signs of life. Soon, one of the Navy crews located and rescued two people from the now rough waters. Hospital Corpsman Third Class (NAC) Jeffrey M. Beaurline said the survivors were both weak and clinging to a barrel. One had second degree burns on his chest, neck and arms. They were treated as the search continued for more survivors. The Coast Guard SAR unit found another survivor in the same vicinity. All three men were transported to a treatment facility in the Dominican Republic.

While the Navy and Coast Guard SAR units were searching, a civilian boat in the area rescued about 25 people. With seven lives still unaccounted for, another Navy SAR crew was sent to the scene.

“We searched for almost two hours with no signs of survivors,” said Hospital Corpsman First Class (AW/FMF/NAC) Steve Mullis. “We were about ready to turn around at sunset, but amidst the 8-foot swells we spotted something. We immediately went from search mode into full rescue mode, dispatching our swimmer and preparing our craft for it’s new passenger. A feeling of elation came over us as we pulled him from the water.”

Mullis added, “from our calculations this man had been floating naked and tired in the water for almost 24-hours. He was so weak he couldn’t even lift his hand.”

“All the training just comes together. It’s good to participate in saving lives,” said Beaurline.

After four days, the rescue attempt was cancelled, but not before the professionals of the Search and Rescue teams were able to save several precious lives.

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Headline: Everybody gets the flu shot

By LT Lara L. Massart, MSC, National Naval Medical Center Bethesda

BETHESDA, Md. – It’s that time of the year when the flu bug strikes and readiness suffers as Sailors become sick in quarters. But the National Naval Medical Center Bethesda launched an aggressive attack against the bug.

The medical center’s aggressive approach resulted in 100 percent participation in the annual flu shot program. What helped? Although staff were required to receive the vaccine unless medically waived or TAD out of the area for an extended period of time, it was tenacity and a well orchestrated vaccination program that did the trick.

The Preventive Medicine staff administered over 6,000 shots during a period of 8 weeks. In addition to 3,350 staff members, over 3,000 other active duty members and government employees from NNMC tenant commands received the annual flu vaccine. This success is attributed to a team of five Preventive Medicine Technicians led by Chief Hospital Corpsman Emmanuel Montenegro, who planned the flu shot program and obtained chain of command support.

Preventive Medicine developed a plan that included a variety of locations throughout the hospital and tenant commands at times that met the needs of different shifts. They generated weekly reports to notify individuals and chain of command of who still required the flu shot. The lists became shorter and shorter each week as staff members complied with the requirement.

In addition to active duty staff working at the medical center, staff members at 23 outlying Branch Medical Clinics also achieved 100 percent compliance. This enormous success is a 15 percent increase over last year, and reflects the personal commitment of every active duty staff member to comply with the annual requirement and maintain C-1 readiness status.

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Headline: TRICARE Prime enrollees get higher priority for access to care

From TRICARE Management Activity

ARLINGTON, Va., -- If you're enrolled in TRICARE Prime, you're higher on the priority list to be treated in a uniformed services hospital than someone who isn't enrolled in Prime.

The policy established by the assistant secretary of defense for health affairs in August 1996 created the following priorities for health care in uniformed services medical treatment facilities:

Priority 1: Active-duty service members

Priority 2: Active-duty family members who are enrolled in TRICARE Prime

Priority 3: Retirees, their family members and survivors who are enrolled in TRICARE Prime;

Priority 4: Active-duty family members who are NOT enrolled in TRICARE Prime (for the purpose of determining access priority, survivors of military sponsors who died on active duty, who are NOT enrolled in TRICARE Prime, are in this priority group)

Priority 5: All other eligible persons (including retirees, their family members and survivors who are NOT enrolled in TRICARE Prime).

There are certain special provisions in the policy:

- Military members who are not on active duty, but who are entitled to care in a service hospital, are in Priority Group 1. This includes members of reserve components entitled to medical care relating to conditions incurred in the line of duty, and members on the Temporary Disability

Retired List for required periodic medical examinations.
- NATO and other foreign military members who are entitled to care in a military medical treatment facility, pursuant to an applicable international agreement are in Priority Group 2, for the scope of the services specified in the agreement.
- NATO and other foreign military members' family members who are entitled to care pursuant to an applicable international agreement are in Priority Group 2, for the scope of services specified in the agreement.
- Survivors of sponsors who die on active duty, as provided in the law-10 U.S. Code 1076(a)-are, for purposes of access to military hospitals, considered to be together with active-duty family members. They would, therefore, be in Priority Group 2 or 4, depending on whether or not they were enrolled in TRICARE Prime.
- Persons other than those in any of the beneficiary groups identified in Priority Groups 1 through 5 don't have priority access.
- Priority access rules are not applicable to bona fide medical emergencies, or cases in which the providing of certain medical care is required by law, or applicable Department of Defense Directive or Instruction. This includes care for civilian employees who are exposed to health hazards in the workplace or are injured on the job.
In certain situations, military hospital commanders may grant exceptions to the priority access rules. For example:
- A higher priority may be given to an active-duty family member who's in Priority Group 4 because TRICARE Prime isn't available where the sponsor is assigned, when the family member is temporarily in a location where TRICARE Prime is available, and needs medical care.
- A particular patient might be given a higher priority if necessary, for the military hospital to maintain an adequate mix of cases for its graduate medical education programs, or to help maintain the readiness-related medical skills of its medical staff.
- A higher priority might be given to a patient in other unexpected or extraordinary cases, as determined by the hospital commander, in coordination with the military lead agent for the TRICARE region.
- And, in overseas locations, other exceptions may be established to
the extent necessary to support mission objectives.

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Headline: TRICARE question and answer

Question: I am retired and my wife and I travel a lot. If we get medical treatment In a certain area, do we submit our claim forms to the DEERS claims office where we are visiting and had treatment, or do we send the claim forms to my official DEERS address.
Answer: You should send the claims form to your official DEERS address. They are still responsible for paying,

although you were out of your assigned area when you received treatment.

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Headline: Healthwatch: Early Detection is Best
By Kimberly A. Rawlings, Bureau of Medicine and Surgery

WASHINGTON -- Women taking this test shouldn't worry about their grade – but they should take the test, because it can mean the difference between life and death.

Pap smear tests, performed annually by a qualified physician, nurse practitioner, nurse midwife or physician assistant, give early warning signs of cancer of the cervix by detecting infections and pre-cancers for early treatment. Captain Steve Remmenga, Specialty Leader for Obstetrics and Gynecology, said abnormal test result does not usually mean cancer, but it is an indication of a potential risk.

"If a diagnosis of cancer is made by a pap smear then we have failed," he said. "The basis of the pap smear test is not to diagnose invasive cancer, but to diagnose changes that are potentially malignant and treat them before they progress to invasive cancer."

According to the American Cancer Society, cervical cancer does not form suddenly. Often, women experiencing early cervical pre-cancers or cancer have no signs or symptoms. The development of the cancer begins with some cells in the cervix that change from normal to pre-cancer and then to cancer. This could take years, although there have been instances where it has occurred quicker.

But whether the cancer forms quickly or over a period of time, Remmenga recommends getting a pap smear. He said the test is about 80 percent accurate with a false rate of 20 percent for either false positive or false negative. The FDA has approved a new, more sensitive and accurate computer-aided diagnosis.

The Navy also recognizes the importance of regular testing. In fact, Bureau of Medicine and Surgery instruction 6320, Annual Health Maintenance Examination for Women, directs that the annual physical examination for women also include a pap smear.

"Thousands of active duty women are diagnosed yearly with abnormal pap smears and require follow up and possible treatment to prevent progression of pre-invasive disease into actual cancer," said Remmenga.

Skin type cells called squamous, represent 85 percent of the cervical cancers. Remmenga said squamous is believed to be a sexually transmitted disease, not an inherited condition because of the sexual transmission component, Human Papiloma Virus (HPV).

"We really do not see a genetic component to cervical cancers," said Remmenga. "Unlike some breast, colon, edometrial (uterine), ovarian and some other cancers, cervical cancer is believed to be triggered by environmental factors such as HPV infections."

The other 15 percent of the cervical cancer patients can

be attributed to glandular cancer called adenocarcinoma, and its variants. The cause of adenocarcinoma is not very clear but there is some indication that HPV may be a contributing factor, said Remmenga. Women that practice unprotected sex, have multiple partners or a history of early sexual activity have the greatest risk.

Smoking is another risk factor for cervical cancer. According to the American Cancer Society, smoking can produce chemicals that may damage the DNA in cells of the cervix and increase the risk of developing cancer.

With no obvious physical signs of an abnormality in the body, the best way to prevent pre-cancers is to have regular pap smear tests. Early detection can stop cervical cancer before it develops fully.

"The earlier you catch it the higher the cure rate," said Remmenga.

Invasive cervical cancer is diagnosed with four major stages, which refer to the location of the disease. Stage One, confined to cervix, has an 85 percent curable rate. The higher the number the more severe the stage of the disease thus reducing the ability to be cured.

A few minutes once a year could prevent any woman from being a statistic from the number one killer in the world and number seven killer in the United States.

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Comments about and ideas for MEDNEWS are welcome. Story submissions are encouraged. Contact MEDNEWS editor, Earl W. Hicks, at email: mednews@us.med.navy.mil; Telephone 202/762-3223, (DSN) 762-3223, or fax 202/762-3224.

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